Washington State Department of Health

Immediately notify
DOH Communicable Disease Epidemiology
Phone: 877-539-4344

Paralytic Shellfish Poisoning

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	Mouth tingling or numbness
☐	☐	☐	☐	Breathing difficulty or shortness of breath
☐	☐	☐	☐	Weakness
☐	☐	☐	☐	Extremities numb
☐	☐	☐	☐	Swallowing or speech difficulty
☐	☐	☐	☐	Eyelids drooping (ptosis)
☐	☐	☐	☐	Vision blurred or double
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Diarrhea Maximum # of stools in 24 hours: ____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Ataxia**
☐	☐	☐	☐	**Cranial nerve abnormalities (bulbar weakness)**
☐	☐	☐	☐	**Paralysis or weakness**
				☐ Acute flaccid paralysis ☐ Asymmetric
				☐ Symmetric ☐ Ascending ☐ Descending
☐	☐	☐	☐	Respiratory distress
☐	☐	☐	☐	**Respiratory failure**
☐	☐	☐	☐	Confusion
☐	☐	☐	☐	Admitted to intensive care unit
☐	☐	☐	☐	Mechanical ventilation or intubation required during hospitalization

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	**High levels of associated dinoflagellates in source water for epidemiologically implicated shellfish**
☐	☐	☐	☐	☐	**Saxitoxin in epidemiologically implicated food**
☐	☐	☐	☐	☐	Food specimen submitted for testing

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date/time (first sx) in heavy box. Count backward to figure probable exposure period

	Exposure period		onset
Hours from onset:	-4	-1	
Calendar dates/times:			

EXPOSURE (Refer to dates above)

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine
				Out of: ☐ County ☐ State ☐ Country
				Dates/Locations: _____
				_____
				_____
☐	☐	☐	☐	Case knows anyone with similar symptoms
☐	☐	☐	☐	**Epidemiologic link to a confirmed human case**

Y	N	DK	NA	
☐	☐	☐	☐	**Shellfish or seafood**
				County or location shellfish collected: _____
				_____
☐	☐	☐	☐	Known contaminated food product
☐	☐	☐	☐	Food from restaurants
				Restaurant name/location: _____
				_____
				_____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y	N	DK	NA	
☐	☐	☐	☐	Outbreak related

PUBLIC HEALTH ACTIONS

☐ Notify others sharing exposure
☐ Notify shellfish program
☐ Initiate trace-back investigation
☐ Other, specify: _____

NOTES

Investigator	**Investigation complete date** ___/___/___
Local health jurisdiction _____	**Record complete date** ___/___/___